

**BEFORE COMPLETING, SEPARATE INTO 2 FORMS BY REMOVING STAPLE.**

**INCIDENT, ACCIDENT, ILLNESS, DEATH OR FIRE REPORT**

**STATE OF MICHIGAN**

Family Independence Agency  
Office of Children and Adult Licensing

**INSTRUCTIONS**

- **The completion of this form may optionally be used to document the requirements of the following licensing rules:**

Child Care Centers R 400.5111, R 400.5865

Children's and Adult Foster Care Camps R 400.11227

Child Placing Agencies R 400.6282

Child Caring Institutions R400.4167(1)(2)

Juvenile Facilities R400.10159(2)

Family and Group Day Care Homes R400.1808(1)(2)

- **The completion and submission of this form to the Agency is required by the following licensing rules:**

Child Care Centers R 400.5111 (2)

Children's and Adult Foster Care Camps R 400.1127 (6)

**FACILITY/HOME/PROVIDER:**

License Number	Facility/Home/Provider Phone Number ( )	
Facility/Home/Provider Name		
Address (Street Number and Name)	County	
City	State	Zip Code

**LICENSING CONSULTANT:**

FACILITY TYPE:	Licensing Consultant Name
<input type="checkbox"/> Day Care Home	
<input type="checkbox"/> Child Care Center	
<input type="checkbox"/> Camp	
<input type="checkbox"/> Child Caring Institution	
<input type="checkbox"/> Juvenile Detention	

**PERSON(S) IN CARE INVOLVED:**

Name	Name	
Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Age
Home Address If Other Than Facility/Home Address (Street Number & Name)	Home Address If Other Than Facility/Home Address (Street Number & Name)	
City	State	Zip Code
Home Phone Number If Other Than Facility/Home ( )	Home Phone Number If Other Than Facility/Home ( )	
Name of Parent (if minor)	Work Phone Number ( )	Name of Parent (If Minor)
		Work Phone Number ( )

**OTHER PERSON(S) INVOLVED / WITNESS(ES):**

Name	Name
Address (Street Number and Name)	Address (Street Number and Name)
Phone Number ( )	Phone Number ( )

**DISTRIBUTION:**

**CHILD PLACING AGENCY:**

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Referring Agency

**CHILD CARING INSTITUTION:**

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Resident Record

**JUVENILE FACILITY:**

Part 1 - Licensing Consultant

Part 2 - Referring Agency

**FAMILY AND GROUP DAY CARE HOME:**

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Home Record

**CHILD CARE CENTER:**

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Center Record

**CHILDREN'S AND ADULT FOSTER CARE CAMP:**

Part 1 - Licensing Consultant (if required by rule)

Part 2 - Camper's Record

The Family Independence Agency will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to an FIA office in your county.

AUTHORITY:  
COMPLETION:  
PENALTY:

P.A. 116 of 1973  
Voluntary/Mandatory  
May be in violation of administrative rule.

Name of Person Notified		Notification Date	Notification Time	Non-Applicable
Physician			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Referring/Responsible Agency (Child Caring Institution Only)			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Probate Court (Juvenile Detention Only)			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Law Enforcement Agency			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Fire Marshal			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Local Coroner			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Family Member			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Other (Specify)			: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	<input type="checkbox"/>
Incident, Accident, Illness, Death or Fire	Time: <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	Location:		
Date:		Description, Cause, Surrounding Circumstances		
If Fire, State Extent of Damage				N/A <input type="checkbox"/>
First Aid Given and When, if Applicable				<input type="checkbox"/>
Who Provided First Aid, if Applicable				<input type="checkbox"/>
Other Action Taken				
Physician's Diagnosis of Injury or Illness, if Applicable				<input type="checkbox"/>
Name of Treating Physician, Medical Facility, Hospital, if Applicable				<input type="checkbox"/>
Phone Number of Treating Physician, Medical Facility, Hospital, if Applicable				<input type="checkbox"/>
Cause of Death, if Applicable	Was an Autopsy Performed <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/>
Were Any Handicaps, Health Problems, or Exceptions Listed on the Child's Health Records? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Signature of Person Completing This Report		Title		Date
Signature of Licensee/Responsible Person		Title		Date